UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ACS RECOVERY SERVICES, INC.,

Plaintiff,

v.

BOBBY HARRIS and GINGER HARRIS,

Defendants.

----------X

AFFIDAVIT OF HENRY S. ROMANO, JR.

07 CV 2946

Judge Berman

STATE OF ILLINOIS :
: s.s.
COUNTY OF COOK :

HENRY S. ROMANO, JR., being duly sworn, upon his oath, deposes and says:

1. I am General Counsel to ACS Recovery Services, Inc. ("ACS"), formerly doing business as Primax Recoveries Incorporated ("Primax" or "ACS"). ACS is a Delaware corporation. I work at ACS's corporate headquarters located at 1301 Basswood Road, Suite 105, Schaumburg, Illinois 60173.

2. ACS is an independent vendor of medical claims recovery to private healthcare payors, third-party administrators, self-funded employee benefit health plans and state and local government employee benefit health plans.

3. ACS's business involves reimbursement and subrogation recovery. ACS identifies, investigates, and recovers

accident-related medical benefits paid or incurred by its plan clients, where other persons or entities have primary responsibility for payment due to contract or laws, by way of equitable enforcement of its clients' liens.

4. Connecticut General Life Insurance Company, a CIGNA HealthCare company ("CIGNA"), contracted with ACS to review and enforce liens with respect to benefits claims made by members of the Fortis Select Benefits Program (the "Plan"), but which may have been caused by other persons or entities.

5. The Plan is an employee welfare benefit plan and is covered by the Employee Retirement Income Security Act.

6. ACS is the assignee of CIGNA's right of subrogation. ACS asserts the rights, claims, and interests of CIGNA in this action.

7. Bobby Harris was a Plan participant through Ginger Harris' employment with Fortis, Inc. Bobby and Ginger Harris were both covered persons entitled to benefits under the Plan.

8. The Plan provides for subrogation, to the extent of payments made to or on behalf of the participant for medical services, when the participant or covered dependent recovers monies from a third party for injuries covered by the Plan. A true and accurate copy of the Plan is attached hereto as Exhibit A.

Mr. Harris' Accident

9. Upon information and belief, on or about December 19, 2000, a truck owned by a concrete company struck Mr. Harris.

10. The Plan disbursed $55,463.84 to pay for Mr. Harris' medical expenses resulting from this accident.

11. Upon information and belief, Mr. Harris, alone or with Ms. Harris, filed a claim with the insurance carrier covering the truck.

12. ACS notified the insurance carrier that the Plan held a lien against any recovery by the Harris', up to the amount the Plan disbursed for Mr. Harris' medical expenses.

13. The Plan also notified the Harris' and/or their attorney of the lien.

14. Upon information and belief, the Harris' settled their claim with the insurance carrier for $675,000.00.

15. The Harris' and their attorney have ignored ACS's demands to honor the lien of $55,463.84, representing the amount paid by the Plan with respect to Mr. Harris' medical expenses.

I declare under penalty of perjury under the laws of the United States of America that the foregoing matters are true and correct.

HENRY S. ROMANO, JR.

Sworn to and subscribed before me
this 12th day of February, 2007

EXHIBIT A

EXHIBIT A

Select

FORTIS SELECT

BENEFITS PROGRAM SUMMARY PLAN DESCRIPTION

11/24
P13:

Virginia Fowler
Client Service Specialist

CIGNA HealthCare

25A Vreeland Road
Suite 202
Florham Park, NJ 07932-1907
Telephone 973.660.4029
Facsimile 973.593.6888

JLY 1997

The Fortis Select Benefit Program

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FORTIS SELECT: THE PHILOSOPHY BEHIND THE PROGRAM

Your compensation is much more than the money you take home in your paycheck. There's an enormous value to the benefits the Fortis companies provide. In fact, company-provided benefits are often called the "hidden paycheck." And, just as we all decide for ourselves how to spend our cash compensation, we all have different priorities when it comes to our company-provided benefits.

The Fortis companies' range of benefit plans gives you and your family a high level of protection and a high level of flexibility in setting your benefits priorities.

Our health care plans help you face the cost of preserving good health. Other plans ensure that a portion of your income is protected if you're sick or disabled and that your family is protected financially if you die.

Fortis believes we should work together to make sure we get the best value for our benefit dollar. Our health care plans provide for preventive care to help reduce the risk of serious, costly illnesses. Our disability plans encourage employees to actively seek rehabilitation in the event of illness or injury.

But let's face it, benefits can be expensive. The company provides a core benefit package at no cost to you. The company also shares in the cost of some of the optional benefits. By working together, we can make the most of our benefit dollars. We can also continue to provide you with benefits that meet the high standards of excellence we set for all of our endeavors.

HOW FORTIS SELECT WORKS

The *Fortis Select* Plan is a flexible benefits program that allows you to choose the coverage that's right for you and your family. There's a whole menu of benefits you can choose from.

Each employee receives a certain number of *Select Credits* from the company. This is like an account which you can draw on to pay for your benefits. Some benefits are considered "core benefits" that everyone needs and therefore, are paid in full by the company. Others are "optional benefits",and are designed so you can pick and choose and adapt your plan to suite your and your family's needs.

If the benefits you choose cost more than your *Select Credits*, you pay the difference. If the benefits you choose cost less than your *Select Credits*, the company will pay you taxable cash in your paycheck.

YOUR FORTIS SELECT BENEFIT OPTIONS

Core benefits in *Fortis Select* are:

- Medical Plan B, employee only
- Employee assistance program
- Basic life insurance (one times plan pay)
- Basic accidental death and dismemberment insurance
- Salary continuation and short term disability benefits
- Long term disability benefits
- Business travel accident insurance

Fortis Select also offers an array of optional benefits:

- Medical Plan options A,B,C or HMO coverage for yourself and your family
- Dental Plan
- Supplemental life insurance benefits
- Supplemental accidental death and dismemberment benefits
- Dependent life insurance
- Health care spending account
- Dependent care spending account
- Vacation options (available only during annual enrollment)

ELIGIBILITY

AM I ELIGIBLE?

You are eligible to participate in the *Fortis Select* program if you are:

- an active, regular, full-time employee, or
- an active, regular part-time employee regularly scheduled to work at least 20 hours a week (30 hours at ASG and ALAC).

You are not eligible for coverage if you are a:

- part-time employee scheduled to work more than 20 hours a week (30 hours at ASG and ALAC) for less than 90 consecutive days, or
- seasonal employee who works less than six months during the calendar year.

Are My Dependents Eligible?

With *Fortis Select*, you can cover your dependents under the Medical, Dental and Dependent Life Plans. Your eligible dependents include:

- your spouse (whom you have married in a ceremony recognized under state law)
- your unmarried children under age 19 (children must be at least 14 days old to be eligible for dependent life insurance)
- your unmarried children under age 24 who are full-time students and dependent upon you for support
- your unmarried children who are permanently and totally disabled (you must provide proof that they are disabled within 31 days after they reach age 19)
- any other person who has not yet reached age 19 and,
  - receives more than half his or her support from you,
  - has your home as his or her principal residence, and
  - for whom you are legal guardian under state law.

Your children include your own or your spouse's natural and adopted children. You can also enroll a child who meets the definition of a dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after your effective date of coverage.

A person cannot be covered under *Fortis Select* as both an employee and a dependent. In addition, if you and your spouse are both employees, only one of you can cover your dependent children under *Fortis Select*.

ENROLLMENT

When Can I Enroll?

You are eligible to enroll in the *Fortis Select* program on the first day that you become an eligible employee.

If you enroll for coverage when you are first eligible for the *Fortis Select* program, you may select any level of coverage without providing evidence of good health. The only exception is life insurance coverage in excess of $1 million.

What Happens If I Don't Enroll?

As a new employee, if you don't enroll within two weeks after the company prints your personalized Enrollment Worksheet, you will automatically be enrolled in these default coverages:

- Medical Plan B (employee only)
- Basic Life (one times plan pay)
- Basic Accidental Death & Dismemberment
- Short Term Disability
- Long Term Disability (paid on an after-tax basis).

If you default, you cannot change your before-tax coverages during the year unless you experience a "life event." You forfeit any extra *Select Credits* you would have received (e.g., for family medical) had you enrolled.

Can I Change My Benefit Selections?

Generally, your benefits remain in effect for the entire plan year. The IRS allows you to change your before-tax elections only if you experience a "life event" as described below.

Because you pay for supplemental life, supplemental AD&D and dependent life insurance with after-tax contributions, you can elect or increase these coverages at any time during the year. However, you (or your dependent) must provide proof of good health before an increase in coverage is effective.

Each year there is an annual enrollment period during which you will have the opportunity to change your benefit selections for the following year. If you want the same benefits to continue, you don't need to re-enroll for the next year. Your benefit selections will automatically continue. But, you do need to make annual elections for your flexible spending account and vacation options. If you don't, these benefits will end as of December 31 of the current calendar year.

If you change your benefit selections during the annual enrollment, you may have to provide proof of good health.

What Events Are Considered "Life Events"?

According to the IRS, "life events" include:

- marriage
- divorce
- legal separation
- birth or adoption of a child
- loss of dependent status (e.g., child attains age 24)
- death of a spouse or dependent
- significant change in employment status or insurance coverage for you or your spouse.

The following restrictions apply to life event changes:

- The change must be consistent with the life event. For example, if you enroll for employee only medical coverage and marry during the year, you can enroll your new spouse for medical coverage.

- You must request and make the change within 31 days of the life event. If you don't make the change within 31 days, you must wait until the next annual enrollment.

- You cannot change from one medical plan option to another or switch to an HMO.

- You can increase your supplemental life insurance amount by only one level, unless you provide proof of good health. The same is true about changes in dependent life insurance for your spouse or child(ren). However, if your dependents were not previously eligible, you can enroll them for any level of life insurance coverage available under the Plan.

- You cannot reduce your health care spending account contribution to an amount that is less than the amount you've already received in reimbursements. Note: You can submit for reimbursement only those expenses incurred while you were participating in the account. So, mid-year changes due to a life event could affect the amount of reimbursement you receive.

- You cannot change your vacation option.

Contact your Human Resources/Benefits Department if you experience a life event and want to make changes in your benefit selections.

EFFECTIVE DATES

You will be covered under the default coverages described on page 4 until you enroll for coverage.

If you enroll within two weeks of when your Enrollment Worksheet is produced, your medical and dental selections will be retroactive to the date you first became eligible. Supplemental life, supplemental AD&D, dependent life insurance and health care and dependent care spending accounts are not effective until you enroll for coverage. If your selection requires proof of good health, you will be insured for the maximum amount of coverage you can receive without proof until it is approved by the insurance carrier.

If you are not actively at work on the date your coverage would normally become effective, coverage will not begin until you return to active work. If your dependent is confined to a hospital (or similar facility) on the date coverage is scheduled to begin, coverage for that dependent will not begin until he or she is discharged. This rule does not apply to a newborn child who is enrolled within 31 days of birth. Note: dependent life insurance coverage for a newborn is not effective until the child is 14 days old.

COST

The company currently pays the full cost of your core benefits, including Medical Plan B, employee only, employee assistance program, basic life insurance, basic AD&D, short term disability and long term disability benefits.

In addition, the company currently pays a portion of the cost for your medical and dental benefits. The company contributes to the cost of these benefits by giving you *Select Credits*.

ALL ABOUT SELECT CREDITS

Select Credits are the company contribution to your benefit plans. The number of *Select Credits* you receive is based on your:

- employment status (i.e., full-time or part-time)
- pay
- benefit selections
- office location

The Tax Status of Your *Select Credits*

The *Select Credits* you use to buy before-tax benefit options are not included in your taxable income. If you do not use all your *Select Credits* and receive them as cash in your paycheck, the amount you receive as cash is taxable.

The Tax Status of Your Benefit Options

Medical, dental, the spending accounts and vacation buy are before- tax benefits. Benefits that you pay for on a before-tax basis reduce your federal income tax. Before-tax contributions will also reduce your Social Security (FICA) tax. This may mean that your Social Security benefits at retirement, death, or disability will be reduced. However, whether your Social Security benefit will actually be lower depends on a number of factors, like your current age, your earnings before participating in the Plans and future pay levels.

Supplemental life, supplemental accidental death and dismemberment, and dependent life insurance are after-tax benefits.

The company provides you with enough *Select Credits* to "buy" your short term disability coverage. But, the company will take an after-tax deduction from your paycheck for your short term disability coverage. The company also gives you the *Select Credits* you need to buy long term disability coverage. But, you have a choice. You may enroll for long term disability benefits on a before or after-tax basis.

The company handles disability coverage this way because it has a significant effect on the tax status of your disability benefits. When you pay for disability coverage on an after tax-basis, any disability benefits you receive are tax-free. If you pay for disability coverage on a before-tax basis, the benefits are taxable. You can use the *Select Credits* the company provides for disability coverage to pay for additional before-tax benefits or receive them in your paycheck (and be taxed on them). This subject is explained further in the Disability section of this book.

How Your Employment Status Affects Your *Select Credits*

If you are an eligible part-time employee, the number of *Select Credits* the company contributes for medical and dental coverage equals a percentage of the credits contributed for full-time employees, as follows:

Regularly Scheduled Hours Each Week	**Company Contributions**
35 hours or more	100% of full-time contribution
25 to 34.999 hours	75% of full-time contribution
20 to 24.999 hours	50% of full-time contribution

If your regularly scheduled hours change during the year and you move into a different bracket, the company will recalculate your *Select Credits* based on your new status. Your contributions for benefits will change accordingly. Note: your contributions will change in the pay period following the period in which your payroll status changes.

If your regularly scheduled hours are reduced to less than 20 hours a week (30 hours at ASG and ALAC), your coverage under the *Fortis Select* program will cease. Your payroll deductions will stop and your *Select Credits* will no longer appear on your paycheck. See the headings entitled "COBRA" and "Conversion" to find out about continuing your benefit coverage.

Your *Select Credits* and Your Pay

The company provides the *Select Credits* you need to buy basic life insurance, basic accidental death and dismemberment insurance, long term disability and short term disability coverage. Your coverage under these Plans is based on your pay. Therefore, the number of *Select Credits* you get to buy these benefits is also based on your pay.

Your *Select Credits* and Your Benefit Selections

Your *Select Credits* will also vary by the level of coverage you select. For example, the company contributes toward the cost of medical and dental coverage for your dependents. So, if you choose to enroll your dependents, the number of *Select Credits* you receive will increase.

If You Are Covered Under Another Medical Plan

If you already have medical coverage (e.g., through your spouse's employer), you can waive medical coverage under the *Fortis Select* program. If you waive coverage, you will get $500 a year in "opt-out" *Select Credits*. You can use these opt-out credits to buy other before-tax benefits or receive them as taxable cash in your paycheck. You must complete a special Medical Waiver form to waive medical coverage and receive your opt-out credits.

Select Credits May Vary Depending On Your Office Location

As described in the Introduction to this book, *Fortis Select* offers health coverage through local HMOs where possible. As a result, there are variations in cost. So, the exact number of *Select Credits* you receive will depend upon your office location and not necessarily the company which employs you. Employees who work in claims and sales offices will receive the same *Select Credits* as home office employees.

Therefore, if you transfer to another office location during the year, the number of *Select Credits* you receive may change.

COVERAGE DURING A LEAVE OF ABSENCE

There are three types of leaves of absence:

- disability leave
- family leave
- personal leave

The status of your benefits during a leave of absence depends upon the type and length of the leave. There is one exception. Business travel accident coverage ends immediately when you begin a leave of absence, regardless of the type of leave.

Disability Leave

If You're Disabled For Up To 13 Weeks

During the first 13 weeks of your disability, your income is protected by the company's salary continuation program. With salary continuation, the company continues to deduct your contributions for *Fortis Select* benefits from your paycheck.

If You're Disabled From 13 to 26 Weeks

After 13 weeks, your income is protected by the short term disability insurance. If you receive short term disability benefits, you may continue your *Fortis Select* benefits by sending payments for your share of the cost to your Human Resources/Benefits Department. If you are receiving short term disability benefits, you do not have to pay for long term disability coverage.

After 26 Weeks

If you are still disabled after 26 weeks, your benefit coverage terminates. But, you can apply for extended medical, dental, employee assistance program (EAP) and health care spending account coverage under the COBRA (see page 13). If you are receiving long term disability benefits AND elect COBRA continuation, the company will continue to contribute to the cost of your medical and dental benefits during the COBRA period.

You may also be eligible for the waiver of premium provision under the life and dependent life insurance policy. If the waiver is approved, your life insurance coverage will continue at no cost to you. If the waiver is not approved, you can convert your life insurance and dependent life insurance to private policies. Accidental death and dismemberment insurance terminates and cannot be converted. You will be notified by Fortis Benefits Insurance Company regarding your eligibility for this benefit.

If you take an approved family leave that meets the requirements of the Family and Medical Leave Act of 1993 (FMLA) or similar state legislation, your *Fortis Select* benefits can continue for up to 12 weeks. The company will continue to contribute toward the cost of your benefit coverage. If you want to continue your benefits, you must pay your share of the cost on a timely basis. Your Human Resources/Benefits Department will contact you regarding your coverage options and the cost to continue these benefits.

If you do not pay your portion of the premium within 30 days of the due date, or if you terminate coverage during the leave, your coverage will terminate retroactive to the last day of the period for which the company received your last premium payment. Any claims you incur while you are not participating in a Plan (including Flexible Spending Accounts) will not be covered. Your coverage may be reinstated as of the date you return from the leave.

You may choose to discontinue your benefits during a family leave. If you decide to discontinue all or part of your coverage, you must make the request in writing within 31 days of the start of your leave. Your coverage can be reinstated when you return from your leave, if you request the change in writing within 31 days of your return.

What Happens If I Extend My Leave Beyond 12 Weeks?

If your leave continues for more than 12 weeks or if you advise the company that you will not be returning prior to the end of the 12-week period, your benefits terminate.

At that point, you can apply for extended medical, dental, employee assistance program (EAP) and health care spending account coverage under the COBRA provisions (see page 13).

You can also convert your life insurance and dependent life insurance coverage to private policies, if you do so within 31 days of the date coverage terminates (see page 15). You can also convert your long term disability coverage to a private policy, if you have been insured under the Plan for at least one year. You cannot convert AD&D and short term disability coverage.

Personal Leave of Absence

Will My *Fortis Select* Benefits Continue?

No. Salary continuation, short term disability and long term disability coverage, business travel accident and flexible spending account participation terminate on your last day of active work.

Your medical, dental, employee assistance program, life, accidental death and dismemberment and dependent life coverage end on the last day of the month in which your personal leave begins.

Are There Provisions For Maintaining Coverage?

You can apply for extended medical, dental, employee assistance program (EAP) and health care spending account coverage under the COBRA provision (see page 13). You can convert your life insurance and dependent life insurance to private policies, if you do so within 31 days of the date coverage terminates (see page 13). You can also convert your long term disability coverage to a private policy, if you have been insured under the Plan for at least one year. But, you cannot convert AD&D and short term disability insurance coverage.

What Happens When I Return To Work?

It's important to preserve your before-tax elections for medical and dental coverage and your participation in the health care spending account while you are on an unpaid leave. There are two ways that you can do this. First, because beginning and ending an unpaid leave of absence are considered life events, you can request to discontinue your coverage during the leave and reinstate it when the leave ends. These requests must be in writing and must be received within 31 days of the date your leave begins or ends, as appropriate. The other way is to continue these coverages through COBRA.

If you return to work within the same calendar year, but do preserve your before-tax elections, your coverage will be reinstated. However, your medical and dental deductions will be taken on an after-tax basis for the balance of the year. Further, you cannot participate in the health care spending account until the following year.

WHEN FORTIS SELECT COVERAGE ENDS

When And Why Could My Benefits End?

There are various reasons your *Fortis Select* benefits could end, and depending on the type of coverage, the termination dates vary, as follows:

- Business travel accident insurance, salary continuation, short term disability and long term disability coverage and flexible spending account participation end on the earliest of the following dates:
  - you fail to make required contributions
  - your employment terminates
  - you are no longer in an eligible class (for example, your work schedule changes to less than 20 hours a week (or 30 hours at ASG and ALAC) or you go on a leave of absence, except as outlined in Coverage During a Leave of Absence)
  - you retire

- Medical, dental, life, and accidental death and dismemberment coverage ends on the last day of the month in which the first of the events outlined above occurs. If you die within 31 days after your basic and supplemental life insurance coverage terminates, your beneficiary will receive benefits under the Plan.

Coverage also ends on the day a Plan is discontinued or is changed to end coverage for an eligible class.

Note: You may be eligible for the Retiree Medical Program as described in "Medical Plan Options" and Retiree Life Insurance outlined in "Life Insurance Options".

When Does Coverage End For My Dependents?

Coverage for your dependents ends when your coverage does or, if sooner, on the last day of the month in which you die or your dependent no longer satisfies the Plans' eligibility requirements.

If your covered dependent dies within 31 days after dependent life terminates insurance coverage, you will receive dependent life benefits under the Plan.

What Happens To My Vacation Benefits?

If you buy extra vacation and terminate before paying for all the purchased vacation time you used during the year, the company will take the balance due from your final paycheck. If the company owes you for vacation time you "sold", the company will add that amount to your final paycheck. This amount is taxed as ordinary income.

What Can I Do If My *Fortis Select* Benefits End?

You (or your dependents) may be eligible to purchase continued coverage in the medical, dental, employee assistance program and the health care spending account under a federal law known as COBRA. COBRA is explained later in this section.

You and your dependents may also have the right to convert your life insurance, dependent life insurance and long term disability coverage to private insurance policies. Refer to Conversion on page 15 of this section for more details.

COBRA – CONTINUING YOUR HEALTH CARE COVERAGE AFTER FORTIS SELECT ENDS

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), gives you and your dependents the right to continue health care coverage after your *Fortis Select* coverage ends. However, there are certain limitations to your COBRA rights. These limitations include the:

- benefits you may purchase
- circumstances surrounding the termination of your *Fortis Select* benefits
- length of time you may continue coverage.

What Benefits Does COBRA Cover?

Your rights under COBRA apply only to your health care coverage: your medical, dental, employee assistance program and health care spending account benefits.

When Does COBRA Apply?

Your COBRA rights apply only if coverage ends due to:

- termination of your employment for any reason other than gross misconduct
- divorce or legal separation from your spouse
- change in a child's eligibility (e.g., a child reaches age 19 and is not a full-time student
- reduction in scheduled work hours
- retirement (but only until you are eligible for Medicare)
- your death.

How Long Does COBRA Coverage Last?

The following table shows how long COBRA coverage can continue:

If Coverage Ends Because	Maximum Continuation Period Is
Your employment terminates (including layoff or approved leave of absence), or a reduction in hours	Up to 18 months for you and your covered dependents Up to 29 months for you and your covered dependents*
Your dependent child is no longer eligible	Up to 36 months for that covered child
You and your spouse are divorced or legally separated	Up to 36 months for your covered spouse
You become eligible for Medicare	Up to 36 months for your covered spouse and dependent children
You die	Up to 36 months for your covered spouse and dependent children

*If you or your dependent is disabled at the time you terminate employment or have a reduction in hours, or at any time during the first 60 days of continuation, you may extend COBRA coverage for up to an additional 11 months. To be eligible for this extension, you or your dependent must:

- receive from the Social Security Administration a determination that you (or your covered dependent) were disabled at the time of your qualifying event or within the first 60 days of continuation
- notify your Human Resources/Benefits Department within 60 days of receiving the disability determination and before the original 18-month period ends.

Your COBRA premium during this 11-month extension period is 150% of the full cost of coverage. You can get additional information about COBRA coverage from your Human Resources/Benefits Department.

COBRA coverage will end earlier if:

- you or your eligible dependent becomes eligible for Medicare benefits. However, if you become eligible for Medicare, your family members may retain continuation coverage for 36 months from the date you first became eligible for COBRA.
- you or your dependents do not make the required payments
- you or your dependents are covered by another group health plan, except a plan that excludes a pre-existing condition for which you or your family member needs treatment
- the company terminates the Plan.

How Do I Apply for COBRA Coverage?

You and/or your dependents must notify the company within 60 days of a divorce, separation or loss of a child's dependent status.

Under other circumstances, the company will send detailed information about COBRA coverage (including its cost) to you or, in the case of your death, to your eligible dependents. You are responsible for the full cost of the coverage you select plus a 2% administrative fee.

If you want COBRA coverage, you and/or your dependents must complete the application and return it to CIGNA within 60 days of the date the company sent you the information or, if later, the date on which coverage terminates. CIGNA will bill you for premiums due beginning with the first day following the date coverage ended. All premiums are due by the first of the month for that month of coverage. You have a 45-day grace period to pay the initial premium. All other premiums must be paid within 30 days of the due date or coverage will terminate.

You must make a separate election for each of the available plans: medical, dental and/or health care spending account.

CONVERSION – CONTINUING YOUR LIFE AND DISABILITY INSURANCE AFTER FORTIS SELECT ENDS

The life and dependent life insurance policy offers you the right to convert to individual coverage when your *Fortis Select* coverage ends. You can also convert your long term disability coverage if you have been covered under the Plan for at least one year. This is called the "conversion privilege." Here's how it works.

You may apply for individual policies under this Plan if your coverage ends because:

- you terminate
- you retire*
- you are no longer in an eligible class [e.g., your regularly scheduled hours are reduced to less than 20 hours per week, (30 hours at ASG and ALAC)]

**You cannot convert your LTD coverage if you retire.*

Your covered dependents may apply for a conversion policy if their coverage ends because they no longer meet the definition of an eligible dependent, you die, or your coverage terminates.

You and your dependents do not have to provide proof of good health to obtain this coverage. The cost of individual coverage will depend upon the insurance company's rates at the time you convert.

To be eligible to convert, you (or your dependent) must apply for a conversion policy within 31 days of the date coverages terminates. Special rules apply for conversion in the event a plan is discontinued or is changed to end coverage for an eligible class. Contact your Human Resources/Benefits Department for the forms and further details.

Section Three: Medical Plan Options

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Select Wellness

Service or Treatment	*Guidelines*

• **Prenatal Care**
  • Office visits
  • Ultrasound examination of fetus[1]
  • Prenatal vitamins	

• **Well Child Care & Immunizations (to age 6)**	As recommended by the Center for Disease Control (CDC) or the American Academy of Pediatrics
• **Mammograms**	Age 40-49 – Once every two years Age 50 and over – Once a year
• **Pelvic Exam and Pap Test**	Once a year
• **Digital Rectal Exam**	Age 40 and over – Once a year
• **Prostate-specific antigen blood test**	

[1] *One ultrasound will be covered under Select Wellness*

No Deductible or Co-Pay!

Select Wellness also provides up to an additional $250 per year for other preventive services such as routine physical exams, hearing tests and immunizations for adults.

Section Three: Medical Plan Options — Schedule of Benefits

Plan Features	*Plan A* *(In PPO Area)*	*Plan B* *(All Areas)*	*Plan C* *(Out of PPO Area)*	*HMO Option* *(Based on Zip Code)*
SELECT WELLNESS	Automatic Coverage	Automatic Coverage	Automatic Coverage	N/A
DEDUCTIBLES				
• Individual	$300	$2,000	$300	N/A
• Family	$600	$3,000	$600	N/A
YOUR SHARE OF COVERED EXPENSES AFTER DEDUCTIBLE:				
• Network Providers (including chiropractors)				
Office Visits[1]	$15 per visit	0%	N/A	HMO providers only
Other Services	10%	0%	N/A	Varies – usually a flat dollar charge
• Out-of-Network Providers				
Office Visits	30%	0%	20%	No benefits for non-HMO providers
Other Services	30%	0%	20%	
PENALTIES FOR:				
• Unhealthy lifestyle	10% additional co-insurance up to a maximum of $1,000 ($2,000 per family)	10% additional co-insurance up to a maximum of $1,000 ($2,000 per family)	10% additional co-insurance up to a maximum of $1,000 ($2,000 per family)	N/A
• Non-emergency use of emergency room	$40	$40	$40	Varies – usually no benefits
SPECIAL PROVISIONS FOR:				
• Mental health/substance abuse treatment	Yes	Yes	Yes	Varies
• Prescription drugs	Card plan	Card plan	Card plan	Varies

[1] *Lab tests and x-rays performed and read by your doctor in his/her office are included in the $15 co-pay.*

MEDICAL PLAN OPTIONS: PRESERVING YOUR PHYSICAL HEALTH

Good health and the ability to get the best possible medical care are among the most important things for you and your family. But as you probably know — whether from personal experience or from following the national debate on health care — good medical care is expensive! So for most of us, health care benefits are just about the most important part of our employee benefit package.

Many changes have occurred in the health care industry over the last ten years. From HMOs (health maintenance organizations) to PPOs (preferred provider organizations), new kinds of health care plans have been introduced in an effort to hold down rising costs while maintaining quality. In many ways, healthcare is a lot more complicated than it used to be. Certainly, we all need to become well-informed health care consumers.

At Fortis, we are continually working to improve our health care benefits. We encourage healthy lifestyles by "investing" in preventive services. We have a financial as well as personal stake in our mutual good health. Therefore, we also encourage getting appropriate care in the most appropriate setting and becoming educated health care consumers.

This section describes the benefits available to you and your family if you enroll in Medical Plan A, B, or C. It also outlines the benefits under the Employee Assistance Program which is available to all regular employees and their dependents. You may also be eligible for a Health Maintenance Organization (HMO). Because we offer many HMOs and benefits vary from HMO to HMO, you should refer to your HMO brochure to learn about its benefits.

All medical plans have limitations and exclusions. It's important that you read and understand these limitations and exclusions **before** you select an option. Remember, you cannot change your medical option during the year.

PLAN HIGHLIGHTS

Use the Schedules of Benefits in the front of this section and the information below to get a general overview of your options and how they work. Be sure to read about the restrictions and limitations in the pages that follow. Important terms appear in bold, italics and are defined at the end of the section.

Select Wellness: Investing In Preventive Care

Catching health problems before they become big, costly problems or simply preventing problems in the first place— that's what *Select Wellness* is all about. This program pays for routine exams, immunizations, pre-natal care and a host of other services that help children and adults preserve good health.

Managed Care Tools: Using Health Care Services Efficiently

"Managed care" is how we describe our effort to use health care services more efficiently through several initiatives. The most important initiative is using a network of hospitals, doctors and health care professionals called a preferred provider organizations (PPO). Other managed care initiatives include pre-certification, continued stay review, and the "Smart Choices" and "Healthy Babies" programs.

Drug Card Program: Reduced Rates On Prescription Drugs

Your benefits for prescription drugs are provided through a drug card program in which participating pharmacies agree to fill prescriptions for members at reduced rates. You pay a flat dollar copay for each covered prescription. You can buy up to a full month's supply for the same low copay.

Mental Health and Substance Abuse Treatment Program

Benefits for mental health and substance abuse treatment are offered through MCC Behavioral Care. Besides providing claims processing services, MCC provides two types of services to the Medical Plan. First, it performs the pre-certification and continued stay review for all inpatient admissions. And it has developed a network of providers for mental health and substance abuse treatment. Similar to the way CIGNA's PPO works, you can receive a higher level of benefits when you use a provider in MCC's network.

The EAP: Confidential Help For Personal Problems

The Employee Assistance Program (EAP) serves as your first contact if you or a family member needs help with an emotional problem, family conflict or substance abuse. The EAP offers assessment, referral and counseling services, and will keep your name and your family members' names confidential.

YOUR MEDICAL OPTIONS

FOUR OPTIONS TO CHOOSE FROM

Fortis Select offers several medical options: Plans A, B, and C, and several HMO options. Your options depend on the availability of provider networks in your area.

- If you live in an area covered by CIGNA's PPO, you are eligible for:
  - Plan A
  - Plan B
- If you live in an area that is not covered by the PPO network, you are eligible for:
  - Plan B
  - Plan C
- If you live within the service area of an HMO, you are eligible for the HMO.

The Medical Plan options available to you appear on your personalized Enrollment Worksheet.

Once a year during annual enrollment you can choose between the Medical Plan options that are offered in your area. You cannot switch between the options until the next annual enrollment period unless you move out of the PPO's/HMO's service area.

For more information on the HMOs available in your area, see your Human Resources/Benefits Department.

DIFFERENCES BETWEEN PLANS A, B, AND C

Plans A, B, and C provide benefits for the same covered services. The differences between these options are their deductibles, co-insurance and out-of-pocket expense limits.

Plan A is available where CIGNA has a PPO. Hospitals, doctors and other specialists who belong to the PPO are called "network providers." Each time you purchase medical goods or services you have a choice. You can either use a network provider or any other qualified health care facility or provider. Plan A has a $300 individual/$600 family deductible.

- **If you use a network provider**, most non-surgical office visits will cost you only $15. (Lab tests and x-rays taken and read by this provider in his/her office will be included in the $15 co-pay.) Plan A pays 90% of the cost of most other covered services after you meet the deductible. When you use a network provider, you know that the fee falls within the Plan's ***reasonable and customary*** fee limits.

- If you choose an out-of-network provider, Plan A pays 70% of covered expenses for most services after you meet the deductible. And, you are responsible for any portion of a provider's charge that is greater than the ***reasonable and customary*** fee limits.

Plan B is available in all areas. Plan B has a $2,000 individual/$3,000 family deductible. Once you meet the deductible, the plan pays 100% of covered expenses for most services and supplies.

Plan C is available in areas where there is no PPO network. After you meet the deductible ($300 individual/ $600 family), Plan C pays 80% of covered expenses for most services and you pay 20%.

The HMO Option

Depending on where you live, you may be eligible to join an HMO instead of participating in Plan A, B, or C. Similar to a PPO, an HMO is an organization that contracts with hospitals, doctors and other health care professionals. However, you must use the doctors and hospitals that contract with the HMO in order for the services to be covered. If you do not, these services will not be covered.

Although benefits vary from one HMO to another, most HMOs offer benefits for preventive health care as well as for the treatment of illness. You are usually not required to submit claims.

COST

How Much Will My Coverage Cost?

You and the company share the cost of medical coverage. The company gives you enough *Select Credits* to cover a portion of the cost of coverage for yourself and, if you choose to enroll them, your eligible dependents. Your contributions depend on the medical option and level of coverage you choose. The amount of your *Select Credits* and your contributions appear on your Enrollment Worksheet.

Once you enroll, any required contributions will automatically be paid on a before-tax basis through convenient payroll deductions.

ENROLLMENT

When you enroll, you choose:

- a Medical Plan option
  and
- the level of coverage that is appropriate for your circumstances.

You can choose from four levels of coverage:

- employee
- employee plus spouse
- employee plus child(ren)
- employee plus spouse and child(ren).

WHAT IF I ALREADY HAVE MEDICAL COVERAGE?

If you have other medical coverage, (e.g., through your spouse's employer), you can waive coverage under *Fortis Select*. If you waive coverage, you will receive $504 a year ($21.00 per pay period) in *Select Credits*.

You can use these *Select Credits* in the following ways:

- buy other benefits
- deposit them in your flexible spending account
- receive them as cash in each pay period — in which case they will be included in your income for tax purposes

Once you make your selection, you cannot change it during the year unless you have a "life event" as described in section, *"Fortis Select "*.

To waive medical coverage, you must complete a *Fortis Select* Medical Waiver form and return it to your Human Resources/Benefits Department.

Can I Change My Selections?

The IRS restricts your ability to make changes in your coverage during the year. You can make changes in the level of your coverage (i.e., employee, employee plus spouse, etc.) at these times:

- during the annual enrollment period (for the following calendar year), or
- within 31 days of a life event.

You will find a detailed explanation of life events and the rules that apply to changes in your coverage resulting from life events in *"Fortis Select"* section of this book.

The only time you can change the medical option you select is during the annual enrollment period. The change will be effective the following January 1.

MORE ABOUT SELECT WELLNESS

Select Wellness is a program designed to help you maintain a healthy lifestyle by providing coverage for preventive health care services. The *Select Wellness* program is one of the most comprehensive programs of its kind. It pays 100% of reasonable and customary fees (or negotiated fee if you use a PPO provider) up to the annual maximum reflects the company's commitment to preventive care.

Who Is Eligible?

When you enroll in Plan A, B or C, you are automatically entitled to the benefits of *Select Wellness.*

What Services Are Covered?

The Schedule of Benefits in the front of this section describes the services covered by *Select Wellness*

Select Wellness benefits for pre-natal visits include the following lab tests:

- complete blood count (CBC)
- urinalysis
- HIV test
- RH antibody
- Rubella antibody titer
- cervical culture
- VDRL
- alpha fetoprotein
- glucose tolerance
- pap smears

Stress tests, non-stress tests and amniocentesis are covered on the basis of medical necessity and will be processed as regular medical expenses, not wellness expenses.

Select Wellness also provides benefits for CBC, urinalysis and pap smears as part of an annual gynecological exam.

How Do These Claims Get Processed?

To be sure you get the most out of *Select Wellness*, it's important that you understand how the program works and share this information with your doctor. Your doctor, lab, or hospital must code your wellness services with routine diagnosis codes to ensure that the claim is processed correctly. If, because of your wellness exam, your doctor diagnoses a medical condition, the routine diagnosis code should still be used as the primary diagnosis code. Your provider should record the medical condition as a secondary diagnosis. Your Human Resources/Benefits Department has a letter, "Dear Health Care Provider," that you can take to your doctor explaining *Select Wellness*.

PENALTIES FOR AN UNHEALTHY LIFESTYLE

The cost of this Plan is shared by us all. So, it is only fair that those who choose unhealthy lifestyles should pay more for their health care than those who are more prudent. With *Fortis Select*, you will pay a penalty if you or any of your covered dependents choose an unhealthy lifestyle.

- **Tobacco Use (of any kind)**
  Each year at annual enrollment, you will be asked if you or your covered dependents have been tobacco-free for at least 12 months. If not, you will pay an additional 10% co-insurance on most medical claims for your entire family.

  If you would like to "kick the habit", many Fortis companies offer smoking cessation programs. Contact your Human Resources/Benefits Representative for details.

- **Accident-related Claims**
  You will also pay a penalty if you or your dependents are injured in an accident and you (or your dependent(s)) were:
  - driving while under the influence of alcohol or illegal substances
  - not wearing a seat belt
  - not wearing a motorcycle helmet (when driving or riding on a motorcycle).

  The penalty for these accident-related claims is an additional 10% co-insurance payment.

The maximum annual lifestyle penalty is $1,000 for an individual or $2,000 for a family. Any penalties you pay for unhealthy lifestyle choices will not be included in your out-of-pocket expense limit.

MANAGED HEALTH CARE TOOLS

PREFERRED PROVIDER ORGANIZATION (PPO)

CIGNA's PPO is a large network of hospitals, doctors, and other health care professionals that delivers high quality medical care cost effectively. The doctors and other health care providers participating in the network have been selected by CIGNA HealthCare, and are subject to CIGNA's ongoing credentialing and quality assurance procedures. PPO providers agree to provide their services at discounted rates. Fortis shares these savings with you by paying a higher level of benefits if you use a PPO provider. That's one advantage to you. The other advantage is that CIGNA's network includes laboratories, chiropractors, physical, occupational and speech therapists, ***home health care agencies, skilled nursing facilities***, and ***hospices*** — types of services that aren't included in many PPOs. Ask your Human Resources/Benefits Representative for a copy of the CIGNA PPO directory.

If I'm in Plan B, Is There Any Advantage To Using a PPO Provider?

Even if you're in Plan B, you can still save on your health care costs by using a PPO provider. If you use a PPO provider, CIGNA will pass along the discounts it has negotiated with the provider to you. Although you still have to meet the $2,000 deductible ($3,000 for a family), you will get more medical care for your money. When you meet your deductible and your claims are paid at 100%, the discounts are passed along to the Plan. These discounts help to hold Plan costs down.

PRE-CERTIFICATION AND CONTINUED STAY REVIEW

Intracorp, a subsidiary of CIGNA, manages cost and preserves high quality medical care through pre-certification and continued stay review. **You must arrange for pre-certification of all inpatient hospital admissions.**

How Do I Pre-Certify A Hospital Admission?

To pre-certify, simply call Intracorp at the toll-free number on the back of your CIGNA identification card. To receive maximum benefits, you must call Intracorp at least five working days before a planned hospital admission and within 24 hours of an emergency or maternity admission.

What Happens If I Don't Pre-Certify My Hospital Admission or Comply With The Continued Stay Review?

If you don't pre-certify your hospital admission and upon review Intracorp determines that the admission was medically appropriate, your benefits will be reduced by 10% to a maximum penalty of $1,000 ($2,000 for a family). If the admission was not medically appropriate, or if you remain in the hospital longer than certified, no room and board charges will be paid for any days not certified by Intracorp.

Emergency Room Use Penalty

It is more expensive to provide medical care in the emergency room of a hospital than in a doctor s office. To encourage you to get treatment in the most appropriate setting, there is a $40 penalty for each time you or a covered dependent is treated in an emergency room in a non- emergency situation. The Smart Choices program described below is available to help you determine whether an emergency room visit is appropriate.

Smart Choices

Sometimes physicians don't take the time to explain the procedures they recommend or what the alternatives are. And sometimes we are too confused or embarrassed to admit that we don't even know what questions to ask. With Smart Choices there s a registered nurse on call 24 hours a day, 365 days a year. The nurses at Smart Choices can translate complex medical information into easy to understand terms.

They can help you:

- prepare a list of questions you need to ask your doctor and explain what to expect during procedures and tests.
- determine if a medical situation can be treated safely at home or if it is an emergency.
- give you access to an Audio Health Library where you can dial in and receive information on more than 400 health-related topics.

So, if your doctor recommends surgery, or your baby has a high fever in the middle of the night, talk to the nurses at Smart Choices. If you need more information about a medical condition, call the nurses at Smart Choices. Help is only a telephone call away. To reach the nurses at Smart Choices call 1-800-982-8958 and select prompt 2.

Healthy Babies Program

Everyone want to have a healthy baby. The "Healthy Babies" program promotes good health during your pregnancy, identifies high-risk pregnancies and reduces the risk of premature births. If you enroll, you will also receive a free copy of the highly recommended book, *From Here to Maternity.* It's easy to enroll. Simply call the toll-free number on the back of your CIGNA identification card.

CENTERS OF EXCELLENCE

CIGNA's Centers of Excellence program is a network of specialized hospitals and physicians that provide the highest quality care for organ and bone marrow transplants. Transplants covered under the program include: heart, heart/lung, lung, liver, kidney/pancreas and bone marrow transplants.

A designated hospital is not a center of excellence for all types of transplants. Rather, CIGNA selects hospitals based on their results with individual procedures. The more frequently a facility performs complex procedures, such as heart transplants, the better able it is to provide the highest quality of care. Before designating a hospital as a center of excellence, CIGNA looks at the facility's:

- experience with the procedure,
- patient survival rates,
- patient care,
- ongoing patient information, and
- medical education programs.

In addition to the services outlined under "Covered Expenses," the program includes all services, supplies and transportation required for the procurement and storage of transplantable organs.

You or a covered dependent may have to travel to receive treatment at an appropriate facility. The Plan will cover the cost of travel and lodging expenses for the patient and one companion. CIGNA must approve the expenses in advance. The maximum travel and lodging expense is $10,000.

You or your doctor may ask about referral to the program by calling Intracorp at 1-800-982-8958.

COVERED EXPENSES

The terms "covered expenses" and "covered services" appear frequently throughout this section. All Plan provisions described in this book apply only to covered expenses/services that you or your dependents incur while covered under the Plan.

What Are Covered Expenses and Covered Services?

Covered expenses include ***reasonable and customary*** charges (or the negotiated fee if you use a PPO provider) for medical services or supplies that are:

- medically necessary — that is, required for the treatment of an illness, injury or pregnancy, in accordance with generally accepted medical practice, and
- provided by a qualified, licensed and accredited hospital or health care facility or, a physician or other health care professional operating within the scope of his or her license.

The term "covered services" refers to the medical services and supplies themselves.

If your doctor charges more than the ***reasonable and customary*** fee as **determined by CIGNA**, the portion of the fee that exceeds ***reasonable and customary*** is not considered a covered expense under the Plan.

The Deductible

The annual deductible is the amount of covered expenses that you must pay before the Plan begins to pay benefits. Your annual deductible is based on the Medical Plan option you select.

	Plan A	Plan B	Plan C
Annual Deductible			
• individual	$ 300	$ 2,000	$ 300
• family	$ 600	$ 3,000	$ 600

The family deductible can be satisfied by any combination of family members. For example, if your family deductible is $600, you might satisfy it as follows:

Your own medical expenses	$200
Your spouse's medical expenses	$200
Your son's medical expenses	$100
Your daughter's medical expenses	$100
Total Family Deductible	**$600**

Once a family member meets his or her individual deductible, the Plan will reimburse you for any additional covered expenses that family member incurs. Once the family deductible is met, the Plan will reimburse you for covered expenses incurred by any covered family member within the limits set by the Plan.

Maximum Out-Of-Pocket Expense

Under this Plan, there is a limit to the out-of-pocket expenses you pay for covered expenses each year. The maximum out-of-pocket expense varies by the Medical Plan option you select. Your maximum out-of-pocket expense is the co-insurance on $10,000 in covered expenses. (Co-insurance is the percentage of covered expenses you pay). The family maximum out-of-pocket expense is the co-insurance on $20,000 in covered expenses for all family members.

What Happens When I Reach the Maximum Out-of-Pocket Limit?

If you reach the maximum out-of-pocket limit for yourself (or a covered dependent), the Plan will pay 100% of most additional covered expenses you (or the family member) incur for the remainder of the calendar year. If you reach the family limit, the Plan will pay 100% of most covered expenses for all covered family members for the remainder of the calendar year.

What Is the Out-of-Pocket Maximum Under Each Plan?

Under Plan A, if you are treated only by PPO providers, your maximum out-of-pocket expense is $1,000 (10% of $10,000). If all your treatment is by providers who are not in CIGNA's network, your maximum out-of-pocket expense is $3,000 (30% of $10,000).

If you enroll in Plan B, your maximum out-of-pocket expense is your deductible.

If you enroll in Plan C, your maximum out-of-pocket expense is $2,000 (20% of $10,000).

Are Any Expenses Excluded From My Out-of-Pocket Maximum?

The following expenses are not included in your maximum out-of-pocket expense:

- deductibles and copays under the Medical Plan;
- deductibles, copays and coinsurance under the Mental Health and Substance Abuse Treatment Program;
- deductibles, copays or other outpatient prescription charges not covered under the Prescription Drug Program;
- penalties applied under any of the above Plan or Programs;
- expenses that exceed the ***reasonable and customary*** fee;
- expenses that are not covered under the Plan.

Covered Expenses and Services

The following are covered expenses/services under Plans A, B, and C:

- hospital room and board in a semi-private room and general nursing services;
- private room, if medically necessary;
- intensive care and coronary care units;
- operating, recovery, treatment, and delivery rooms;
- hospital emergency room and outpatient department;
- urgent care facilities;
- birthing centers;
- ***skilled nursing facilities;***
- ***hospices;***
- surgery, including necessary postoperative care. When multiple surgeries are performed during one operating session, the most expensive procedure is paid as any other surgery. However, the covered expense for the second (or third) procedure is reduced to 50% of the usual charge for the second (or third) procedure.
- second surgical opinions;
- home, office and other outpatient visits;
- maternity services, including prenatal and post-natal care, miscarriage, abortions and treatment of complications due to pregnancy;
- services of a midwife, if provided under the direct supervision of a physician;
- amniocentesis;
- x-rays, ultrasounds, cat scans, magnetic resonance imagings (MRI);
- laboratory services;
- anesthesia and its administration;
- drugs and medicines administered while in a hospital or while in a doctor's office;
- oxygen, blood and blood products and their administration;
- medical and surgical dressings, supplies, casts and splints;
- chemotherapy and radiation therapy;
- hemodialysis;
- physical and occupational therapy;
- speech therapy for restorative or rehabilitative treatment for speech loss or impairment due to illness or surgery;
- home health care;
- chiropractic treatment (subject to a $1,000 annual maximum benefit);
- acupuncture, if performed by a physician or a licensed acupuncturist;
- ambulance services to the closest facility to provide appropriate care for your or your covered dependent s condition. This can be from your home or from the scene of an accident or medical emergency to a hospital or B&I skilled nursing facility. It can also be between hospitals and ***skilled nursing facilities*** and from a ***skilled nursing facility*** to your home. This includes air and surface transportation;

- rental of durable medical equipment (e.g., respiratory devices, wheelchairs, crutches). If the cost to rent the equipment is greater than the purchase price, the equipment will be purchased;
- artificial limbs or other prosthetic appliances (e.g., orthopedic braces, breast prostheses, artificial eyes);
- dental care which results from an accidental injury to sound, natural teeth sustained while covered under the Plan and hospital charges related to the surgical extraction of teeth;
- services of a Christian Science Practitioner.

MAXIMUM BENEFITS

The following maximum benefit limits apply:

- the lifetime maximum benefit is $2,000,000. This maximum includes benefits paid under the Prescription Drug and Mental Health and Substance Abuse Treatment Programs
- the maximum benefit for the treatment of a pre- existing condition during the first 12 months of coverage is $25,000. (Refer to the detailed explanation below).
- the annual maximum for chiropractic treatment is $1,000
- the annual maximum benefit for *Select Wellness* is $250, except as outlined in the Schedule of Benefits

THE PRE-EXISTING CONDITION LIMITATION

WHAT IS A PRE-EXISTING CONDITION?

The Plan sets limits on the benefits you can receive for a pre-existing condition. A pre-existing condition is a medical condition for which you or your dependent receive treatment, medical services or prescription medicine during the three months immediately before your coverage under the Plan begins.

What Are The Benefit Limitations For A Pre-Existing Condition?

If you or any of your dependents have a pre-existing condition, the Plan will pay a maximum of $25,000 in benefits for the treatment of that specific condition during the first 12 months of coverage under the Plan.

This limitation does not apply if:

- you waived coverage under *Fortis Select* and you or your dependent loses coverage under the other group plan (you must enroll for coverage under *Fortis Select* within 31 days),
- you switch between *Fortis Select* options at the annual enrollment.

EXPENSES THAT ARE NOT COVERED

The following expenses are not covered by the Plan:

- services not medically necessary as determined by CIGNA, except as covered under *Select Wellness*;
- expenses resulting from the failure to comply with the Plan s pre-certification or continued stay review, unhealthy lifestyle penalties or penalty for using an emergency room in a non-emergency situation;
- prescription drugs or medications except those administered while in a hospital or at a doctor's office (benefits for other prescriptions or medications may be available under the Prescription Drug Program);
- cosmetic surgery except reconstructive surgery required because of a previous surgical procedure which was necessary to treat an infection or disease, or when medically necessary to correct damage caused by an accident or an injury, or to correct a congenital defect;
- reversal of voluntary sterilization procedures;
- charges for or in connection with artificial insemination, in vitro fertilization, embryo transfer procedures, or any other infertility treatments;
- amniocentesis, ultrasound, or any other procedures requested solely to determine the sex of the fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder;
- transsexual surgery and related services;
- speech therapy unless it is expected to restore speech to a person who has lost existing speech function as the result of a disease or injury;
- ambulance service which is not medically necessary;

- inpatient private duty nursing;
- aversion therapy, educational therapy, recreational therapy or any form of non-medical self-care or self-help and any related diagnostic training services;
- chelation except in connection with an FDA approved diagnosis;
- massage therapy;
- chiropractic treatment determined by CIGNA to be routine or maintenance;
- nutrition or dietetic services unless in connection with diabetes;
- weight loss treatment unless the person is determined to be morbidly obese. An accepted course of treatment is either gastric bypass or gastroplasty and may include a hospital stay to reduce weight before surgery;
- routine foot care, orthopedic shoes or supports, and orthotics;
- surgical treatments for correction of refractive errors, including radial keratotomy;
- eyeglasses or contact lenses except the first pair of lenses or glasses following cataract surgery;
- charges incurred in connection with the purchase or fitting of hearing aids;
- treatment of teeth/periodontium except emergency dental work to stabilize teeth due to injury to sound natural teeth (other dental work may be covered under the Dental Plan);
- appliances and orthodontic treatment for temporomandibular joint (TMJ) dysfunction (these supplies/treatment may be covered under the Dental Plan);
- ***experimental*** procedures and treatments not approved by the American Medical Association;
- services rendered by an immediate family member;
- charges in excess of the ***reasonable and customary*** fee, as determined by CIGNA;
- any sickness or injury covered under workers compensation or any similar law;
- care which is primarily ***custodial*** in nature and not intended to treat a specific injury or sickness, or any education or training;
- charges for any physical fitness or exercise equipment;
- charges or services which are covered under the Mental Health and Substance Abuse Treatment Program;
- charges incurred in connection with or arising from a felony;
- reports, evaluations, examinations or hospitalizations not required for health reasons;
- charges incurred for services and supplies which are furnished, paid for or otherwise provided by reason of past or present service in the armed forces;
- charges which the person is not legally required to pay;
- services or supplies provided by physicians acting outside the scope of their licenses;
- expenses incurred before your coverage begins or after your coverage ends;
- charges in excess of the Plan's annual or lifetime maximums;
- charges incurred more than two years before the claim is received by CIGNA.

PRESCRIPTION DRUG PROGRAM

Claims for outpatient prescription drugs under Medical Plans A, B, and C are processed by Diversified Pharmaceutical Services through their drug card program.

Diversified negotiates volume discounts on prescription drugs with a large network of more than 49,000 pharmacies throughout the country. This network includes most chains such as Walgreens, K-Mart, Osco Drug, Duane Reade and Shopko, and many smaller independently-owned pharmacies.

How Does It Work?

If you use a Diversified-participating pharmacy, simply present your Diversified I.D. card to the pharmacist each time you fill a prescription. Because Diversified negotiates volume discounts, your prescription will cost less than if you purchase the drug at a non-participating pharmacy. For a small copay, you will receive up to a one-month supply of a covered medication, unless limited by the drug manufacturer's packaging or the prescription order. If your prescription costs less than the copay, you will only pay for the cost of the prescription. There are no claim forms to file when you use your drug card at participating pharmacies.

Payment for prescriptions does not constitute an assumption of liability for any illness or injury.

The following chart outlines the features of this program.

Features	Plan A/C	Plan B
Deductible[1]		
– Individual	$0	$100
– Family	$0	$200
Copay		
– Generic	$7.00 (up to a 1 mo. supply)	$7.00 (up to a 1 mo. supply)
– Brand name	$12.00 (up to a 1 mo. supply)	$12.00 (up to a 1 mo. supply)
Annual Out-of-Pocket Maximum		
– Individual	$ 750	$ 850
– Family	$1,000	$1,200

[1] The deductible must be satisfied before the copay applies. Charges for purchasing brand name drugs when a generic equivalent is available do not apply to your deductible or out-of-pocket maximum.

In addition to outpatient prescription drugs, the program covers insulin syringes, glucose testing strips, lancets and diaphragms with a prescription order from a physician.

Benefits payable under the Prescription Drug Program will be included in your Medical Plan lifetime maximum benefit.

What's The Difference Between Brand and Generic Drugs?

After drug patents are exhausted, prescription drugs become available in generic form. The FDA approves the manufacture of generic drugs after a lengthy review process. Drugs categorized as "generic equivalents" receive the FDA s highest rating. The FDA review process ensures that the generic equivalents have the same effects in the body as their brand name counterparts.

In order to effectively manage drug costs and utilization, benefits for drugs available in both brand name and generic form are based on the cost of the generic equivalent. Therefore, if you purchase a brand name drug when a generic equivalent is available, you will pay your copay plus the cost of the brand name minus the generic drug cost.

What If I Use A Non-Participating Pharmacy?

If you use a pharmacy that does not belong to the Diversified network, you will have to pay for the full cost of the prescription. You can then file a claim with Diversified. Diversified will only reimburse you the discounted amount it would have paid a participating pharmacy for the cost of the drug. You are responsible for any additional cost. Your additional cost does not apply to your deductible or out-of-pocket maximum.

Prior Authorizations

Certain medications require "prior authorization" before benefits are considered under the drug card program. This information is available on-line at your pharmacy at the time your prescription is filled. Your pharmacist works with Diversified and your Human Resources/Benefits Representative to administer this program. Although the list is subject to change and information is updated through the on-line system, the drugs listed below currently (6/1/97) require prior authorization.

- DDAVP
- Miacalcin
- Nimotop

You should contact your Human Resources/Benefits Representative for information on how you can have one of these drugs pre-authorized.

What Expenses Are Not Covered Under the Prescription Drug Program?

The following expenses are not covered under the Program:

- any part of a prescription order that exceeds a one-month supply, except prenatal vitamins which are available in a three-month supply
- medications administered by injection unless approved the Plan
- any charge for the administration or injection of any drug, immunization agents, biological sera, blood or blood plasma (these charges may be considered for coverage through CIGNA);
- medications that can be obtained without a prescription, which have over-the-counter equivalents or have the same active ingredients as an over-the counter medication; compounded drugs not containing at least one legend ingredient (an ingredient that cannot be dispensed without a prescription);
- dietary supplements and vitamins, except prenatal vitamins during pregnancy; herbal or homeopathic medications
- drugs which have no FDA-approved indications for use (e.g., Progesterone products), drugs administered for conditions or in dosages that are not FDA approved; drugs used in a manner not approved by the FDA;
- contraceptive devices, except diaphragms;
- prescription refills greater than the number specified on the physician's prescription order or refills dispensed more than one year after the date of the original prescription;
- drugs covered under workers' compensation or any similar law;
- drugs covered under another medical plan which is the primary payor;
- drugs administered or dispensed in a physician's office or hospital including unit dose drugs;
- drugs prescribed for cosmetic purposes, treatment of hair loss, or weight loss; growth hormones; any drug used to change skin color or to facilitate smoking cessation, or the treatment of non-organic sexual dysfunction;
- medicine used in the treatment of infertility or to facilitate pregnancy;
- Retin-A for a covered person age 30 or older;
- drugs used in the treatment of primary nocturnal enuresis (bed wetting) for a covered person under the age of six;
- any drug that is not consistent with the diagnosis and treatment of the illness, injury or condition, or that is excessive as to the scope, duration or intensity of drug therapy needed to provide safe, adequate and appropriate care;
- any drug that is solely for the covered person's convenience or the convenience of the family or physician;
- replacement prescriptions needed because of loss, damage or theft.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PROGRAM

Fortis Select offers coverage for mental health and substance abuse (MHSA) treatment. The benefits are provided by MCC, a subsidiary of CIGNA. MCC is the oldest and one of the largest behavioral care providers in the country. It has developed a carefully selected and credentialed provider network nationwide. You have access to care 24 hours a day, 365 days a year simply by calling **1-800-554-6931.**

Pre-Certification And Continued Stay Review

MCC performs pre-certification and continued stay review services for the MHSA Program. All inpatient treatment (in-network and out-of-network) must be pre-certified by MCC.

How Do I Pre-Certify?

To pre-certify a hospital admission, call MCC at the toll-free number on the back of your CIGNA identification card. To receive maximum benefits under the Program, you must pre-certify an admission within 24 hours.

What Happens If I Don't Pre-Certify My Hospital Admission Or Comply With The Continued Stay Review?

If you don't pre-certify a hospital admission, and upon review MCC determines that the admission was medically appropriate, benefits will be reduced by 10% to a maximum penalty of $1,000 ($2,000 for a family). If the admission was not medically appropriate, or if you remain in the hospital longer than certified, no room and board charges will be paid for any days not certified by MCC.

What Are the Benefits For MHSA Treatment?

Benefits for MHSA treatment are the same under Plans A, B, and C and are outlined below.

	In Network	Out-of-Network
Inpatient		
Deductible	$0	$300 (ind)/$600 (fam)
Coinsurance (your share of covered expenses)	10%	30%
Annual out-of-pocket max	none	none
Lifetime maximum benefit	Included in Medical Plan lifetime maximum	$50,000 (included in Medical Plan lifetime maximum)
Outpatient		
Deductible	$0	$300 (ind)/$600 (fam)
Copay/coinsurance	$15 copay/visit	50%
Annual out-of-pocket max	$400	none
Annual maximum benefit	none	$3,000
Lifetime maximum benefit	Included in Medical Plan lifetime maximum	Included in Medical Plan lifetime maximum

If you receive treatment from out-of-network providers, your deductibles and co-insurance do not apply to the Medical Plan or the Prescription Drug Program deductibles or out-of-pocket limits.

Benefits for substance abuse treatment are limited to two courses of treatment per lifetime.

FILING CLAIMS

How Do I File Claims?

If you do not participate in the Health Care Flexible Spending Account, you shouldn't file claims until you have met your annual deductible. CIGNA, Diversified, and MCC charge administrative fees every time a claim is processed, whether or not a payment is made. By not filing a claim before you are eligible for reimbursement, you will help hold down the cost of claim processing.

If you are enrolled in Plan A and use network providers, they will file the claims for you. If you use an out-of-network provider or you enroll in Plan B or Plan C, you must file claims to receive benefits.

If you have a medical or mental health/substance abuse claim, complete a Group Medical Direct Reimbursement Claim Form and send it to the appropriate address listed below:

Medical Claims
CIGNA Health Care Service Center
P.O. Box 8012
Plainville, CT 06062
1-800-962-3368

Mental Health and Substance Abuse Claims
MCC Behavioral Care
1195 Viking Drive
Eden Prairie, MN 56344
1-800-926-2273

If you are filing a prescription drug claim, use a Diversified Prescription Drug Claim Form and send to:

Diversified (FTS)
Mail Route #2152
P.O. Box 4999
International Falls, MN 56649-4999
1-800-233-8065

When you file a claim, be sure to:

- use a separate form for each family member
- include your Social Security number
- indicate whether you want payment to be made to you or directly to your health care provider.

You can either attach itemized bills or have your doctor complete the Physician's Statement section of the form. Either way, you must include the following information:

- patient's full name, date of birth and relationship to you
- doctor's name, address and tax identification number
- diagnosis
- services performed
- date and charge for each service

A custodial parent may file claims for a child covered under a Qualified Medical Child Support Order. The claims payor will pay benefits to the custodial parent.

Claims received by the claims payor more than two years after the date the services are performed are not eligible for reimbursement.

COORDINATION OF BENEFITS

How Does *Fortis Select* Work With Other Benefits?

Today many people have coverage under more than one group medical plan. Rules, called "coordination of benefits" provisions, have been developed by the insurance industry to determine which plan is the primary carrier — the one that must pay benefits first. The following is a summary of these rules:

- A benefit plan without a coordination of benefits provision will pay benefits before a plan which contains such a provision.
- The plan which covers the person as an employee pays benefits before the plan which covers the person as a dependent. For example, the *Fortis Select* Plan is the primary carrier for your expenses. Your spouse's plan is primary for his/her expenses.
- The plan of the parent born earlier in the year is the primary carrier for a dependent child. In the case of a divorce or separation, the plan of the parent with custody is the primary plan, unless a court decree names one parent responsible for providing medical coverage.
- If the above three rules do not establish a primary plan, then the plan which has covered the person longer is primary.

The *Fortis Select* Plan is administered under a Maintenance of Benefits (MOB) payment method. Under MOB, when *Fortis Select* is the secondary carrier, the benefit payable under the primary carrier will be deducted from the benefit normally paid by Fortis Select. You will receive benefits up to but no greater than the *Fortis Select* benefits.

An Example Of The MOB Payment Method

Assume your spouse had surgery and the fee was $600. You have already met your deductible. Your spouse's plan (which is primary) paid 80% ($480) in benefits. *Fortis Select* Plan A would pay:

	In-Network (90% coverage)	**Out-of- Network** (70% coverage)
Surgeon's Fee	$ 600	$ 600
Fortis Select Normal Payment	540	420
Less Spouse's Plan Benefit Payment	– 480	– 480
Fortis Select Payment	60	0
Your Out-of-Pocket	$ 60	$ 120

As you can see from this example, if you or your dependents have medical coverage under more than one group plan, it is important that you weigh the benefit you receive from this double coverage against the premium cost to carry both plans.

RIGHT OF RECOVERY AND SUBROGATION

If you or a covered dependent is injured by another party, the Plan has the right to be reimbursed for benefits it paid if damages are recovered from the responsible party. For this purpose, "responsible party" includes anyone who has an obligation to compensate you for the injury, including your own auto insurance company under its uninsured or underinsured provisions.

The Rules of Recovery and Subrogation

- By filing a claim for benefits under the Plan or by receiving benefits from the Plan, you automatically assign, transfer, and subrogate to the Plan all rights, claims, and interests that you have against a responsible third party. In addition, you agree to repay the Plan if you recover from the responsible party any losses paid by the Plan.

- You are required to cooperate with the Plan in pursuing its right of recovery. This means that you are required to keep the Plan informed about the progress of your claims against the responsible party. If you do not pursue a claim, you may be required to assist the Plan in pursuing a claim. You must obtain written consent from the Plan Administrator before you settle any claims against any responsible party.

- The Plan's right of recovery applies to the proceeds of any amount you receive from the responsible party regardless of whether the amount is called reimbursement of medical expenses, or whether you believe the amount fully compensates you for your injury. The Plan's right of recovery applies to the net amount you receive (net of attorneys fee and other expenses.) The Plan does not share your cost of recovery.

- If you refuse to cooperate with the Plan in enforcing its right of recovery, settle a claim without the Plan's consent, or if you refuse to repay the Plan after recovering from the responsible party, the Plan will reduce payments on any future claim by the amount you owe the Plan. The Plan may also bring legal action against you to recover the amount you owe.

RETIREE MEDICAL PROGRAM

WHO IS ELIGIBLE?

You are eligible to participate in the Retiree Medical Program if you retire from a Fortis company on or after January 1, 1993 with at least 15 years of credited service under the Fortis, Inc. Employees Uniform Retirement Plan. There are two parts to the Program. Part I applies to retirees under age 65. Part II applies to retirees over age 65.

Recognizing that the cost of medical coverage is high, the Fortis companies include a special company contribution feature in this Program. The company contribution will help you pay for coverage available under Part I and Part II.

PART 1 — EARLY RETIREMENT MEDICAL PLAN

When you retire, you can elect to continue medical coverage for yourself and your eligible dependents through the Early Retirement Medical Plan administered by CIGNA. Or, if you prefer, you may arrange your own coverage through another insurer or HMO.

If you elect the company-sponsored plan and you live in an area serviced by CIGNA'S Preferred Provider Organization (PPO), you will be enrolled in Plan A. If you live outside of an area serviced by CIGNA's PPO you will be enrolled in Plan C.

Claims should be submitted to the following address:

CIGNA HealthCare Service Center
P.O. Box 8012
Plainville, CT 06062

How Much Will the Plan Cost?

Each year the company will determine the cost of coverage. Premiums are higher than under the active employee plan to reflect the higher medical costs associated with early retirees. The maximum annual company contribution is the lesser of:

- one-half the cost of individual coverage under the company-sponsored plan and
- $100 for each year of your service up to 25 years or $2,500.

The company contribution will change annually as the cost of medical coverage increases, up to your maximum annual company contribution.

You may cover your spouse under this program, even after you reach age 65 and become eligible for Medicare. You may also cover your eligible children as long as at least one parent (i.e., you or your spouse) participates in the Early Retirement Medical Plan. You are responsible for the entire cost of coverage for your dependents.

Must I Enroll In A Company-Sponsored Plan To Receive A Contribution?

No. The company will contribute to the cost of your coverage whether you purchase medical coverage through the company-sponsored plan or an alternative plan. But, you must purchase medical coverage in order to receive the company contribution. If you arrange for coverage elsewhere (e.g., through your spouse's employer) the company will reimburse you up to the amount it would have contributed toward the company-sponsored plan. If you pay for this alternative coverage on an after-tax basis, the company contribution will not be included in your taxable income. If the premiums for the alternative coverage are paid for on a before-tax basis, the company contribution will be included in your taxable income.

If you enroll in the company-sponsored plan, CIGNA will bill you each month and notify you in the fourth quarter of each year of any premium increase for the following year. You send your premium payments directly to CIGNA at the address on the invoice. If CIGNA does not receive your premium payment within 31 days of the due date, your coverage will be terminated.

Part II — Retiree Reimbursement Plan

The Retiree Reimbursement Plan applies to all eligible retirees and their spouses age 65 and over. This is true regardless of your age at retirement.

When you reach age 65, Medicare is the primary source of your medical coverage. The Retiree Reimbursement Program helps you pay for additional coverage to supplement Medicare. This kind of coverage is often referred to as "Medigap" coverage. Many insurance companies and some HMOs sell "Medigap" policies. Your Human Resources/Benefits Department can help you arrange for Medigap coverage. Depending on the state where you live, you may have a choice of up to ten standard Medigap plans.

How Is the Company's Contribution Determined?

You pay the full cost of any Medigap policy you purchase. The company will reimburse you for a portion of your cost. The maximum annual company contribution equals the lesser of:

- one-half of the estimated average cost of an individual Medigap policy with broad coverage and
- $100 for each year of your service up to 25 years or $2,500.

As the average cost of a Medigap policy increases, so will the company contribution to your premium, up to your maximum annual company contribution.

There are a wide variety of Medigap policies available. If the one that best meets your needs costs less than the company contribution, you may apply the balance to the premium for dependent coverage.

How Do I File A Claim For Reimbursement?

You must complete a Fortis, Inc. Retiree Reimbursement Program Claim Form and send it along with one of the following types of documentation to the address on the form. Your Human Resources/Benefits Department has the forms you need.

- a copy of the premium statement showing a previous payment received;
- a copy of a canceled check
- a copy of a bank statement showing an automated payment to the insurer;
- a copy of a paystub showing the medical contribution;
- a letter from an employer verifying the medical premium payment;
- a letter from a bank or insurance company verifying payment.

If you die during the year, the company will use any funds remaining in your account to help pay for your spouse's medical insurance for the remainder of the calendar year.

You must file claims for reimbursement by March 31st of the following year. You will receive Retiree Reimbursement Activity Summary statements in November and in January notifying you of the amount in your account and the amount reimbursed to date.

ADDITIONAL INFORMATION

For more information about your rights under the Plan, refer to the "Plan Administration" section.

DEFINITIONS

CUSTODIAL SERVICES

The term custodial services means any services which are not intended primarily to treat a specific injury or sickness (including mental illness, alcohol or dug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as (a) walking; (b) grooming, (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered and;
- services not required to be performed by trained or skilled medical or paramedical personnel.

Emergency Services

Emergency Services are medical, surgical, hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an injury or a sudden, unexpected onset of a serious Sickness which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment to bodily functions. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Provider Organization, in accordance with generally accepted medial standards; to have been an acute condition requiring immediate medical attention.

Experimental

Procedures or treatments not approved by the American Medical Association or the appropriate medical specialty society.

Home Health Care Agency

The term Home Health Care Agency means a hospital or a non-profit or public income health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Reasonable and Customary

A charge will be considered reasonable and customary if:

- it is the normal charge made by the provider for similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is reasonable and customary, the nature and severity of the injury or sickness being treated will be considered.

SKILLED NURSING FACILITY

The term skilled nursing facility means a licensed institution (other than a hospital) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of physicians; and (c) provides nurses' services.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Everyone has personal problems at some time in their lives. Usually we can handle them by ourselves. But sometimes a problem gets out of hand and resolving it seems impossible. You can call your EAP 24 hours a day, 7 days a week. EAPs provide confidential assessment, referral, and treatment for a range of personal problems including:

- marital problems,
- depression,
- difficulties with children,
- alcohol or drug abuse,
- stress,
- domestic violence,
- financial worries, and
- legal problems.

The EAP is staffed by licensed professionals in psychology, clinical social work, and counseling. EAP services for employees of Fortis Benefits Insurance Company-Kansas City and First Fortis Life and their dependents are provided through New Directions. New Directions' toll-free number is **1-800-669-6777.** EAP services for all other Fortis companies are provided by MCC Behavioral Care. You can reach MCC at **1-800-554-6931**.

What Happens When I Call The EAP?

First, you will speak with one of the EAP's specially trained staff members. He or she will ask you what kind of problem you are having, and will then assist you in scheduling an appointment with an EAP counselor. (If you are in crisis when you call, you will be connected to a counselor immediately.)

Often, the problem can be resolved in just a few sessions. The EAP provides up to eight visits free of charge. However, if your problem requires longer treatment, your EAP counselor will help you find the best available resource in the community for dealing with your particular situation. If you (or your dependent) are enrolled in the Medical Plan, benefits for these services may be available under the option you selected. You should refer to section "Mental Health and Substance Abuse Treatment Program" in this book or your HMO brochure for information on the available benefits.

Section Four: Dental Plan — Schedule of Benefits

	In-Network	*Out-of-Network*
DEDUCTIBLE:		
• **Individual**	$50	$50
• **Family**	$100*	$100*
YOUR SHARE OF COVERED EXPENSES: (AFTER THE DEDUCTIBLE)		
• **Preventive/Diagnostic Services****	0%	0%
• **Basic Services** (e.g., fillings, extractions, scaling and root planing)	10%	20%
• **Major Services** (e.g., dentures, bridges, gold inlays)	40%	50%
• **Orthodontic Services****	50%	50%
MAXIMUM ANNUAL BENEFIT	$1,500 for preventive/diagnostic, basic and major services (per person)	
MAXIMUM LIFETIME ORTHODONTIA BENEFIT	$1,000 per person	

Two family members must each satisfy a deductible in order to meet the family deductible.

***Deductibles do not apply.*

Section Four: Dental Plan

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DENTAL BENEFITS: REDUCING THE FINANCIAL "PAIN" OF DENTAL CARE

The *Fortis Select* Dental Plan is designed to encourage you and your family to maintain a regular program of dental care. The Plan emphasizes preventive care — encouraging sound dental health through regular checkups and preventive dentistry.

Fortis Select offers benefits through a dental preferred provider organization, Dental Health Alliance. You can choose to stay within the network or go outside it each time you need dental care. You can call DHA's toll-free number, 1-800-985-9895, to find a preferred provider near your home or office.

PLAN HIGHLIGHTS

Four Types of Dental Services

The Dental Plan pays benefits for four types of dental services:

- preventive/diagnostic services, like routine exams and cleanings,
- basic services, like simple extractions and fillings,
- major services, like dentures, crowns and inlays, and
- orthodontic services (after a 12-month waiting period).

The Schedule of Benefits in the front of this section summarizes the most important features of the Plan. Be sure to read the text of this book for a more detailed explanation of your benefits. Important terms are printed in bold, italics and defined at the end of this section.

An Added Benefit: The Vision Hardware Discount

When you enroll in the Dental Plan, you automatically become a member of the Preferred Vision Care (PVC) Discount Program. PVC's network of eyewear providers will give you a substantial discount — an average of 50% off of eyeglasses! — when you show your Fortis Dental Plan I.D. card. There are no claim forms to fill out and no deductible to pay.

COST

How Much Will My Coverage Cost?

You and the company share the cost of your dental coverage. The company gives you enough *Select Credits* to cover a portion of the cost of coverage for yourself and, if you choose to enroll them, your eligible dependents.

Your contributions depend on the level of coverage you choose (employee, employee plus spouse, etc.). The amount of your *Select Credits* and your contributions appear on your Enrollment Worksheet.

ENROLLMENT

When you enroll, you choose the level of coverage that is appropriate for your circumstances. You can choose from four levels of coverage:

- employee
- employee plus spouse
- employee plus child(ren)
- employee plus spouse and child(ren).

Can I Waive My Dental Benefits?

Yes. Enrollment is optional. However, if you waive coverage for yourself or your dependents during your initial enrollment period and later decide to enroll, you are considered a late entrant and special limitations apply.

Can I Change My Selections?

In exchange for the advantages of before-tax contributions, federal law limits your ability to change your selections during the year. The only times you can change your enrollment are:

- during the annual enrollment period or
- within 31 days of a life event.

Refer to section two of this book, *Fortis Select*, for a complete explanation of these rules.

What Are The Late Entrant Provisions?

For the first 12 months of coverage, benefits for late entrants are limited to preventive/diagnostic and basic services. After that, you and/or your dependents will be eligible for the Plan's normal coverage for all preventive/diagnostic, basic, major and orthodontic services. These limitations do not apply if you add coverage within 31 days of a life event.

THE DEDUCTIBLE

The deductible is the amount that you must pay for ***covered expenses*** before benefits are payable from the Plan for basic and major services. You must meet a new deductible each calendar year.

How Much Is The Deductible?

The annual deductible is $50 for an individual and $100 for a family. To meet the family deductible two members of the family must satisfy their individual deductibles. For example, if both you and your spouse each satisfy your individual deductible of $50, your family deductible is met. But, if you satisfy your individual deductible and two of your dependents accumulate $25 each toward their individual deductibles, your family deductible is not met.

The deductible does not apply to preventive/diagnostic and orthodontic services.

PLAN BENEFITS

What Will the Plan Pay For Dental Services?

Your share of ***covered expenses*** will depend on whether you use a network provider as outlined below:

Type of Service	In-Network	Out-of-Network
Preventive/Diagnostic	0%	0%
Basic	10% after the deductible	20% after the deductible
Major	40% after the deductible	50% after the deductible
Orthodontic	50%	50%

The maximum annual benefit payable from the Plan is $1,500 for each covered person. The maximum lifetime benefit for orthodontic services is $1,000 for each covered person. The lifetime maximum benefit for orthodontia is reduced by any payments you received for orthodontia under a prior Fortis plan.

COVERED EXPENSES

Benefits are based on the ***usual, reasonable and customary*** fee (or the negotiated fee if you use a network provider) for ***covered services*** when performed by a ***qualified dental professional.*** Fortis Benefits Insurance Company determines the ***usual, reasonable and customary*** fee for a ***covered service.***

The following is a partial list of ***covered services*** under the four main categories of dental expenses.

PREVENTIVE/DIAGNOSTIC

- Oral Exams – limited to once in any 6-month period;
- Complete Series X-rays or Panoramic Film – limited to once in any 60-month period;
- Bitewing X-rays – limited to once in any 12-month period;
- Dental Prophylaxis – limited to either 1 dental prophylaxis or 1 periodontal maintenance in any 6-month period;
- Fluoride Treatment – limited to once in any 6-month period and to children under age 16;
- Sealants – limited to one time per tooth in any 36-month period and to children under age 16 on permanent molars;

BASIC

- Emergency Oral Exams – covered only if no other treatment (except X-rays) is rendered during visit;
- Intraoral Periapical, Intraoral Occlusal, and Extraoral X-rays – limited to once in any 6- month period;
- Other X-rays – excluding X-rays related to orthodontic procedures or TMJ dysfunction;
- Root Canal Therapy – limited to once on same tooth in any 24-month period. Includes pre-op, operative and post-op tests, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care;
- Periodontal Scaling and Root Planing – limited to once per quadrant in any 24-month period;
- Periodontal Maintenance Procedure (following active treatment) – limited to 1 dental prophylaxis or 1 periodontal maintenance procedure in any 6-month period;
- Simple Extraction/Oral Surgery;
- General Anesthesia and Intravenous Sedation – considered for payment as a separate benefit only when medically necessary (as determined by Fortis Benefits) and when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Plan;
- Consultations – considered for payment only if billed by a dentist who is not providing operative treatment;
- Amalgam Restorations – replacements limited to 12 months after the placement for children under age 19 and after 36 months for anyone age 19 or over;
- Composite Restorations – replacements limited to 12 months after the placement for children under age 19 and after 36 months for anyone age 19 or over. Benefits for composite fillings on posterior teeth limited to corresponding amalgam filling;
- Therapeutic Drug Injections;

MAJOR

- Inlays, Onlays and Crowns – covered when the tooth cannot be restored by an amalgam or composite filling and the person is at least 17 years old;
- Repairs, Adjustments and Replacement of Inlays, Onlays and Crowns – repairs and adjustments are limited to once in any 12 month period and to more than 12 months after insertion. Replacements are not covered unless 7 years have elapsed since the last placement;
- Recementing Inlays, Onlays, Crowns and Bridges;
- Periodontal Surgery – limited to once per quadrant in any 36 month period. Limitation applies to gingivectomy, gingival curettage, mucogingival or osseous surgery;
- Full Dentures and Partial Dentures;
- Repairs, Adjustments and Replacement of full dentures and partial dentures – repairs and adjustments are limited to once in any 12 month period and to more than 12 months after insertion. Replacements are not covered unless 7 years have elapsed since the last placement and the denture cannot be made serviceable. Partial dentures less than 7 years old will be covered if replacement is necessary due to the extraction of an additional tooth;
- Fixed Bridges (including Maryland Bridges) – covered for a person who is at least 17 years old;
- Repairs, Adjustments and Replacement of fixed bridges – repairs and adjustments are limited to once in any 12 month period and to more than 12 months after initial insertion. Replacements are not covered unless 7 years have elapsed since the last placement and the bridge cannot be made serviceable. Bridges less than 7 years old will be covered if replacement is needed due to the extraction of a tooth not abutting the existing bridge.

ORTHODONTIA

Covered orthodontic services include:

- initial consultation
- moldings and impressions
- installation of braces
- monthly visits

Typically, benefit payments for orthodontia are made over the full course of treatment, as follows:

- an initial examination fee
- an installation fee
- quarterly installments (based on fees for three monthly visits).

SPECIAL PROVISIONS

ALTERNATE DENTAL PROCEDURES

Often there is more than one way to treat a particular dental problem. When this happens, the alternate procedure provision applies. This means that the Plan pays benefits based on the least costly dental procedure **provided that the procedure is adequate to promote good dental hygiene.** To determine the benefit payable, Fortis Benefits Insurance Company's dental consultant reviews both the proposed procedures and the materials involved.

If you and your dentist choose the more expensive treatment, then you are responsible for paying the difference in cost.

MISSING TEETH LIMITATION

The Plan will not pay benefits for the replacement of teeth missing on or before your or your dependent's coverage is effective. However, the Plan will pay benefits for:

- the initial placement of full or partial dentures if the placement includes the initial replacement of a functioning natural tooth extracted while you or your dependent was covered under the Plan and
- the initial placement of a fixed bridge if the placement included the initial replacement of a functioning natural tooth extracted while covered under the Plan. However, the following restrictions will apply:
  - — the extracted tooth will not be considered a covered dental expense if it was an abutment to an existing prosthesis;
  - — benefits will only be paid for the replacement of the teeth extracted while you or your covered dependent were covered under the Plan;
  - — benefits will not be paid for the replacement of other teeth which were missing on your or your covered dependent's effective date.

PREDETERMINATION OF BENEFITS

The Plan's predetermination of benefits provision allows you to find out ahead of time how much the Plan will pay for a proposed course of dental treatment.

How Does Predetermination of Benefits Work?

Before starting a course of dental treatment that is expected to cost $300 or more, you submit the charges to Fortis Benefits Insurance Company for a pre-treatment estimate. You follow the same procedure and use the same form that you would if you were filing a claim. Fortis Benefits Insurance Company will write to both you and your dentist, letting you know how much the Plan will pay if you are covered under the Plan when the services are performed.

If there is an alternative treatment to one that your dentist proposes that is less expensive but which produces a "professionally satisfactory result," the Plan s reimbursement will be based on the cost of the alternative treatment. A predetermination of benefits will also advise you whether:

- the services are ***covered expenses*** under the Plan and
- the charges are within ***usual, reasonable and customary*** allowances.

If there is a significant change in the treatment plan, you should request a new estimate.

Is A Predetermination of Benefits Required?

No. But it is often to your advantage to do so because the pre-treatment estimate allows you to plan ahead. Both you and your dentist know how much the Plan will pay before proceeding with the work.

EXTENSION OF BENEFITS FOR TREATMENT IN PROGRESS

What If My Coverage Ends In the Middle Of Treatment?

If you've begun a course of dental treatment and your coverage terminates before the treatment is complete, the Plan will pay benefits for the completion of preventive/ diagnostic, basic and major services for 30 days from the date your coverage ends. If you are in the middle of orthodontic treatment when your coverage ends, the Plan will pay benefits through the quarterly installment that is due as of the day your coverage ends.

MAXIMUM BENEFITS

The Plan pays a maximum benefit for all eligible dental expenses of up to $1,500 a calendar year for each covered family member.

There is a lifetime maximum benefit of $1,000 for orthodontic services. This lifetime maximum benefit is reduced by any payments you received for orthodontia under a prior Fortis plan.

EXPENSES THAT ARE NOT COVERED

The following is a partial list of expenses that are not covered under the Dental Plan:

- treatments which:
  - are not included in the list of covered dental expenses;
  - are not dentally necessary, as determined by FBIC;
  - are experimental in nature;
  - do not have uniform professional endorsement;
- procedures that are covered under the Medical Plan;
- appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting;
- treatments or appliances in which the sole or primary purpose of which relates to:
  - the change or maintenance of vertical dimensions;
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder (TMJ);
  - bite registration; or
  - bite analysis;
- replacement of lost or stolen appliances or prostheses;
- educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions;
- completion of claim forms or missed dental appointments;
- personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders;
- treatment for a jaw fracture;
- services provided by an ***immediate family member***;
- hospital or facility charges for room, supplies or emergency room expenses or routine chest X-rays and medical exams prior to oral surgery;
- services performed outside the United States except for emergency dental treatment. The maximum benefit payable to any person during a plan ear for covered dental expenses related to emergency dental care performed outside the United States is $100;
- treatments covered under any workers' compensation or similar law;
- treatments which are reimbursable by or through a plan of any governmental agency including Medicare, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. The Plan will always reimburse any state or local medical assistance (Medicaid) agency for covered dental expenses;

- treatments provided primarily for cosmetic purposes;
- treatments which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years, as determined by Fortis Benefits Insurance Company;
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
- bacteriological studies;
- provisional splinting; or
- excision of pericoronal tissues
- claims received by Fortis Benefits Insurance Company more than one year after they were incurred.

FILING CLAIMS

To file a claim you must complete a claim form and send it to Fortis Benefits Insurance Company at the following address:

Company Plan Claims Administrator
P.O. Box 419401
Kansas City, MO 64141-6401

Be sure to:

- include your Social Security number
- use a separate form for each family member
- indicate whether you want payment to be made to you or directly to your dentist.

Claims must be received by Fortis Benefits within one year of the date the services are performed.

SHOULD I INCLUDE THE DENTIST'S BILL WITH MY CLAIM?

You can either attach itemized bills or have your dentist complete the provider's statement section of the form.

Either way, you must include the following information:

- patient's full name, date of birth and relationship to you
- dentist's name, address and tax identification number
- diagnosis, and
- date and charge for each service

You can get dental forms from your Human Resources/Benefits Department.

How the Plan Works With Other Dental Plans

The Plan has a Coordination of Benefits (COB) provision that is designed to prevent duplication of benefits when you or an enrolled dependent is covered under more than one group dental plan. The following is a summary of these rules:

- A benefit plan without a COB provision will pay benefits before a plan which contains such a provision.
- The plan which covers the person as an employee pays benefits before the plan which covers the person as a dependent. For example, the *Fortis Select* Plan is the primary carrier for your expenses. Your spouse's plan is primary for his/her expenses.
- The plan of the parent born earlier in the year is the primary carrier for a dependent child. In the case of a divorce or separation, the plan of the parent with custody is the primary plan, unless a court decree names one parent responsible for providing dental coverage.
- If the above rules do not establish a primary plan, then the plan which has covered the person longer is primary.

If the *Fortis Select* Plan pays second, it pays an adjusted benefit which, combined with the benefit from the primary plan, equals up to 100% of covered dental expenses.

THE VISION HARDWARE DISCOUNT BENEFIT

If you enroll in the *Fortis Select* Dental Plan, you and your covered dependents are eligible for the vision hardware discount benefit. This special benefit is part of the Preferred Vision Care Discount Program (PVC). This is a network of independent providers of eyewear products. Through PVC, these providers offer you substantial discounts on eyewear. When you purchase eyewear from network providers, you will pay the wholesale price for eyeglasses and save at least 20% off the retail price for contact lenses and related items. The network provider will charge a modest dispensing fee to cover his or her time.

Locating the PVC provider in your area is easy, simply call **1-800-635-7874**. Remember, to get your discount, you must show your Fortis Benefits dental insurance identification card.